Frontiers in Public Health Services and Systems Research

Volume 2 | Number 1 Article 3

January 2013

# Hospital Tax-Exempt Policy: A Comparison of Schedule H and State Community Benefit Reporting Systems

Sara Rosenbaum
*George Washington University*, sarar@gwu.edu

Maureen Byrnes
*George Washington University*, mkbyrnes@gwu.edu

Amber M. Rieke
*George Washington University*, amorley@gwu.edu



## Recommended Citation

Rosenbaum S, Byrnes M, Rieke AM. Hospital Tax-Exempt Policy: A Comparison of Schedule H and State Community Benefit Reporting Systems. Front Public Health Serv Syst Res 2013; 2(1).
DOI: 10.13023/FPHSSR.0201.03

# Hospital Tax-Exempt Policy: A Comparison of Schedule H and State Community Benefit Reporting Systems


## Abstract

The Patient Protection and Affordable Care Act (ACA) revises federal tax exemption standards for nonprofit hospitals by clarifying and augmenting their community benefit obligations. The ACA amendments followed the 2009 launch of Schedule H – the form on which hospital community benefit, financial, and institutional activities are reported and which must be appended to each facility's annual Form 990 nonprofit institution information return. Schedule H effectively creates a nationwide, standardized, facility-specific, transparent, and fully publicly accessible reporting system covering the nation's more than 2,900 nonprofit hospitals. Schedule H delineates financial assistance and bad debt, and requires identification of community health improvement and community building. Many states have attempted to capture similar information regarding nonprofit hospitals' community benefit activities through their own reporting systems. We analyzed state statutes and reporting systems for a sample of 24 states. We found that, in general, state laws lack the clarity of the IRS approach in terms of how community benefit is defined, categorized and reported. In contrast to Schedule H, state laws tend to be broadly drawn, with considerable variability in terms, less delineation among bad debt and financial assistance, and variability in treatment of community health improvement and community building.

## Introduction

The Patient Protection and Affordable Care Act (ACA) clarifies and augments the community benefit requirements governing federal tax exemption for nonprofit hospitals.[1] Among other reforms, the ACA requires that nonprofit hospitals conduct community health needs assessments (CHNAs) and develop implementation strategies that clearly tie hospital investments to community needs.

The concept of community benefit was first established by the Internal Revenue Service (IRS) in 1969 and, since 2009, the IRS has required all nonprofit hospitals to report their community benefit expenditures on a "Schedule H" worksheet. [2] This worksheet, which is appended to the Form 990 that all tax-exempt organizations must file annually with the IRS, effectively creates a publicly accessible, facility-specific, nationwide reporting system that enables an assessment of how individual hospital community benefit investments are linked to community needs identified in a CHNA, and it provides a singular opportunity to compare hospital investments geographically and (when merged with other data) by other variables such as size, location, and patient mix. It also raises important questions for state policy makers and health professionals. First, how does Schedule H compare to existing state laws related to measuring and reporting community benefit? And second, what considerations might justify the continuation of state reporting in light of the availability of Schedule H? To answer these questions, it is important to understand the extent to which Schedule H may broaden the knowledge base regarding hospitals' community benefit expenditures.

Schedule H

Schedule H expressly delineates certain types of activities that are considered a community benefit, such as (1) provision of "financial assistance" consisting of "free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services"; (2) hospital costs in connection with hospital participation in Medicaid and other means-tested entitlement programs; and (3) multiple sub-categories of activities, including "community health improvement" services, defined as

> "activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient bills, although there may be a nominal patient fee or sliding scale fee for these services." [3]

In addition, the IRS recognizes evidence-based "community building" activities as a community benefit. These activities represent an important set of federally recognized activities because they rest squarely on the social conditions of health, such as physical improvements and housing,

[1] Patient Protection and Affordable Care Act, Public Law No. 111-148, §9007, 124 Stat. 855, (March 2010): 737-741.
[2] Internal Revenue Service, Schedule H (Form 990) 2011: Hospitals (Revised 2012), accessed August 2, 2012, http://www.irs.gov/pub/irs-pdf/f990sh.pdf
[3] 2011 Instructions for Schedule H: 13.

economic development, community support, environmental improvements, leadership development and training for community members, among others.[4]

The IRS also draws a clear delineation between what it considers community benefits, as described above, and how it treats bad debt and losses associated with hospitals' Medicare participation. Neither is considered a community benefit under federal law. The IRS expressly defines "bad debt" as "uncollectible charges that the organization recorded as revenue but wrote off due to a patient's failure to pay."[5]

## Methods

To better understand state community benefit reporting, we examined laws and regulations in 24 states categorized by the Catholic Health Association[6] and The Hilltop Institute[7] as having "mandatory" reporting requirements (in some cases, state reporting may be mandatory for certain elements and voluntary for others.) (See Table 1) We looked only at states with mandatory reporting systems since they would readily compare in purpose and structure to Schedule H. We collected statutory language through legal database searches, and reporting forms and instructions from state agency websites. We focused on three questions that arise from the basic attributes of Schedule H: first, whether public reporting is required; second, whether terminology is clear and consistent with the definitions found in Schedule H; and third, whether state reporting requirements capture information about community health improvement and community building, two types of activities that transcend the narrower class of community benefit activities focusing on financial assistance and reflect the broader role for hospitals in improving community health that is anticipated in the ACA's CHNA provisions.

## Results

*1. Public reporting*

Twelve of the 24 states specify that hospital reports must be publicly available. Five states assign a state agency with responsibility for analyzing expenditures and creating public reports regarding hospital expenditures with some level of data aggregation. Eight states have reporting forms accessible online. No form exactly parallels Schedule H; state forms tend to lack the precise definitions found in Schedule H, and frequently lack one or more of the Schedule H reporting categories.

*2. Clear, consistent terminology*

Terminology and definitions in state statutes vary widely. (See Table 2) For example, California includes Medicare shortfalls in its definition of community benefit, while Minnesota specifically excludes them. Many states do not use the term "community benefit." Instead they use "indigent

[4] Schedule H (Form 990) 2011: Hospitals: 2.
[5] 2011 Instructions for Schedule H: 2.
[6] Catholic Health Association, "Community Benefit Voluntary Reporting by U.S. State," (August 2010).
[7] Donna C. Folkemer, Martha H. Somerville, Carl H. Mueller et al, "Hospital Community Benefits After the ACA: Building on State Experience," *The Hilltop Institute Issue Brief* (April 2011): 10, accessed August 1, 2012, http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-HCBPIssueBrief2-April2011.pdf



https://uknowledge.uky.edu/frontiersinphssr/vol2/iss1/3
DOI: 10.13023/FPHSSR.0201.03

care" (which may or may not include financial assistance, bad debt, and shortfalls from government programs in addition to Medicaid and means-tested programs). Other states use broader concepts such as "charitable use of property," which may recognize more than the precise definitions of community benefit investment found in federal law. It is uncommon for states to delineate between financial assistance and Medicaid participation on the one hand, and bad debt and Medicare participation on the other, as Schedule H does.

**Table 2:** Variation in Definition of Community Benefit: Selected State Laws

| State Statute | Definition of Community Benefit |
|---|---|
| California Health and Safety Code §127345 | "[C]ommunity benefit" means a hospital's activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status, including, but not limited to, any of the following:<br>(1) Health care services, rendered to vulnerable populations, including, but not limited to, charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and those eligible for Medi-Cal, Medicare, California Childrens Services Program, or county indigent programs.<br>(2) The unreimbursed cost of services included in subdivision (d) of Section 127340.<br>(3) Financial or in-kind support of public health programs.<br>(4) Donation of funds, property, or other resources that contribute to a community priority.<br>(5) Health care cost containment.<br>(6) Enhancement of access to health care or related services that contribute to a healthier community.<br>(7) Services offered without regard to financial return because they meet a community need in the service area of the hospital, and other services including health promotion, health education, prevention, and social services.<br>(8) Food, shelter, clothing, education, transportation, and other goods or services that help maintain a person's health. |
| Illinois Compiled Statutes §210 ILCS 76 | "Community benefits" means the unreimbursed cost to a hospital or health system of providing charity care, language assistant services, government-sponsored indigent health care, donations, volunteer services, education, government-sponsored program services, research, and subsidized health services and collecting bad debts. "Community benefits" does not include the cost of paying any taxes or other governmental assessments. |
| Indiana Code §16-21-9-1 | "[C]ommunity benefits" means the unreimbursed cost to a hospital of providing charity care, government sponsored indigent health care, donations, education, government sponsored program services, research, and subsidized health services. The term does not include the cost to the hospital of paying any taxes or other governmental assessments. |
| Maryland Health General Code Annotated §19-303 | "Community Benefit" means an activity that is intended to address community needs and priorities primarily through disease prevention and improvement of health status, including:<br>(i) Health services provided to vulnerable or underserved populations such as Medicaid, Medicare, or Maryland Children's Health Program enrollees;<br>(ii) Financial or in-kind support of public health programs;<br>(iii) Donations of funds, property, or other resources that contribute to a community priority;<br>(iv) Health care cost containment activities; and<br>(v) Health education, screening, and prevention services. |
| Minnesota Statutes §144.699 | "[C]ommunity benefit" means the costs of community care, underpayment for services provided under state health care programs, research costs, community health services costs, financial and in-kind contributions, costs of community building activities, costs of community benefit operations, education costs, and the cost of operating subsidized services. The cost of bad debts and underpayment for Medicare services are not included in the calculation of community benefit. |

| | |
|---|---|
| Nevada Revised Statutes §449.490 | "[C]ommunity benefits" includes, without limitation, goods, services and resources provided by a hospital to a community to address the specific needs and concerns of that community, services provided by a hospital to the uninsured and underserved persons in that community, training programs for employees in a community and health care services provided in areas of a community that have a critical shortage of such services, for which the hospital does not receive full reimbursement. |
| New Hampshire Revised Statutes Annotated §7:32 | "Community benefits" means a health care charitable trust's activities that are intended to address community health care needs including, but not limited to, any of the following:<br>(a) Charity care.<br>(b) Financial or in-kind support of public health programs even if the programs extend beyond the trust's service area, including support of recommendations in any state health plan developed by the department of health and human services.<br>(c) Allocation of funds, property, services, or other resources that contribute to community health care needs identified in a community benefits plan.<br>(d) Donation of funds, property, services, or other resources which promote or support a healthier community, enhanced access to health care or related services, health education and prevention activities, or services to a vulnerable population.<br>(e) Support of medical research and education and training of health care practitioners, including the pooling of funds by different health care charitable trusts for this purpose. |
| Oregon Administrative Rules §409-023-0100 | "Community benefits" mean programs or activities that provide treatment or promote health and healing as a response to identified community needs. They are not provided primarily for marketing purposes or to increase market share.<br>(a) Community benefit must meet at least one of the following criteria:<br>(A) Generate negative margin;<br>(B) Improve access to health services;<br>(C) Enhance population health;<br>(D) Advance knowledge;<br>(E) Demonstrate charitable purpose.<br>(b) Community benefit activities must be counted in only one of the following categories:<br>(A) Charity care;<br>(B) Losses related to Medicaid, Medicare, State Children's Health Insurance Program, or other publicly funded health care program shortfalls;<br>(C) Community health improvement services;<br>(D) Health professionals' education;<br>(E) Subsidized health services;<br>(F) Research;<br>(G) Financial and in-kind contributions to the community;<br>(H) Community building activities;<br>(I) Community benefit operations. |
| Rhode Island General Laws §23-17.14-4 | "Community benefit" means the provision of hospital services that meet the ongoing needs of the community for primary and emergency care in a manner that enables families and members of the community to maintain relationships with person who are hospitalized or are receiving hospital services, and shall also include, but not be limited to charity care and uncompensated care. |
| Texas Health & Safety Code §311.042 | "Community benefits" means the unreimbursed cost to a hospital of providing charity care, government-sponsored indigent health care, donations, education, government-sponsored program services, research, and subsidized health services. Community benefits does not include the cost to the hospital of paying any taxes or other governmental assessments. |

*3. Community Health Improvement and Community Building*

Six states specify reporting categories that resemble federal "community health improvement" activities, but their terminology lacks the precision of Schedule H. For example, Illinois requires



https://uknowledge.uky.edu/frontiersinphssr/vol2/iss1/3
DOI: 10.13023/FPHSSR.0201.03

a description of "other community benefits," but the category is undefined. Thirteen states do not require reporting on community health improvement activities. Five states require hospitals to report "community building" investments that relate to the social conditions of health. Four of the five break community building into categories that mirror Schedule H.

## Implications

Discounted care for community residents lies at the heart of the concept of community benefit. However, it is clear that compared to state law, Schedule H more precisely distinguishes between the types of discounted care that can be considered true community benefits – financial assistance and Medicaid participation – and those activities that simply are business losses to a hospital, such as Medicare shortfalls or bad debt.

Schedule H also incentivizes investments in a more diverse array of community health improvement activities. This move toward a more expansive definition of community benefit will be particularly important as hospitals move forward with CHNAs and implementation strategies and as broader coverage of the population under health reform moves toward full implementation, thereby freeing up revenues previously allocated to discounted care.

Our findings raise the question of whether states should retain their own reporting systems or more explicitly rely on Schedule H. Clearly a state may wish to maintain separate reporting obligations as an essential element of state tax policy. If so, it might consider a Schedule H filing as deemed compliance with its own reporting requirements. A state might also retain its own reporting laws to assure that the data are analyzed, aggregated, and reported to policymakers and the public. Such reports will be particularly valuable as CHNA and implementation strategy activities move forward. Whatever states decide, Schedule H is an essential and invaluable tool for federal and state governments to measure hospital performance in relation to their obligations as tax-exempt institutions, as well as to benchmark hospitals on a state, regional and nationwide basis.

**Table 1:** State Community Benefit Reporting Summary and Reporting Elements

| State | What reporting is required of hospitals? | Does state separate bad debt from financial assistance, subsidized services and/or costs of government programs? | Are community building & community health improvement services reported? | Is state agency required to publicly report data? |
|---|---|---|---|---|
| **Alabama** | Hospitals must certify that 15% of business is charity care for property tax exemption. "Charity work" is certified by the County Tax Assessor, which reports to Department of Revenue. No other reporting elements are specified. | Only charity work is reported. | Community health improvement services and community building are not included in statute. | There is no requirement for public reporting at the hospital or state level. |
| **California** | Private nonprofit hospitals must submit a community benefit plan to the Office of Statewide Health Planning and Development in the State Department of Health Services. Certain elements are defined as community benefit, such as charity care and the unreimbursed costs of government programs. There is no standardized format for hospital plans. | Charity care, discounted care and costs of government programs are included in the statute's definition of community benefit expenses, but not required to be itemized separately. Bad debt is not included, nor explicitly excluded. | Goods and services that increase access, promote health, or meet a community need are included in the statute's definition of community benefit, but not required to be itemized separately. | The Office of Statewide Health Planning and Development makes individual hospital reports available to the public, but does not aggregate data. |
| **Connecticut** | All hospitals are required to file annual reports disclosing charity care and debt collection policies, as well as financial data such as uncompensated care provided. Reports and forms are submitted to the Office of Health Access in the Department of Public Health. | Charity care, bad debt, Medicare and Medicaid are reported separately on provided form. | Community health improvement services and community building are not included in statute or reporting form. | The Office of Health Access must submit a report on "information concerning the financial stability of hospitals" to the General Assembly. The publicly available report includes state amounts for charity care and bad debt, though the statute does not require it. |

| | | | | |
|---|---|---|---|---|
| **Georgia** | Counties participating in state's Hospital Care for the Indigent Program must submit an annual budget to the Department of Public Health to receive allocated funds. | Costs of care for indigent patients is included in the annual budget. Other categories are not identified. | Community health improvement services and community building are not included in statute. | There is no requirement for aggregated public reporting by county or state. |
| **Idaho** | Hospitals are required to provide information about charity care provided under the Catastrophic Health Care Costs Program for indigent medical expenses. Hospitals submit IRS Form 990 ("or comparable information") and charity care costs to the Board of the Catastrophic Health Care Costs Program. | Charitable care costs are reported. Bad debt and costs of government programs are not included in statute, but Form 990 or comparable information is required. | Community health improvement services and community building are not included in statute. Form 990 or comparable information is required. | The Board of the Catastrophic Health Care Costs Program is required to prepare an annual report for the program. There is no requirement for aggregated public reporting. |
| **Illinois** | Nonprofit hospitals must submit annual community benefit plans, in addition to disclosing charity care provided, bad debt, and cost of government-sponsored indigent care. The reporting categories are defined in a form provided by and submitted to the Attorney General. | Charity care and bad debt are reported separately. All costs of government programs are reported as one line item. | One line is included for "other community benefits" on the reporting form. A detailed description of how benefits are provided and calculated is required for the category. | Hospital reports are available to public by request to Attorney General. There is no requirement for aggregated public reporting. |
| **Indiana** | Every hospital must file annual financial disclosures with the Department of Health, including charity care and other expenses. Nonprofit hospitals also file a community benefit plan with the State Department each year. The submitted plan includes a form for accounting community benefits provided, including charity care. | Charity care, subsidized services, itemized bad debt expenses, and government programs are reported separately. | Disclosure of the amount and types of community benefits provided are required in community benefit plan. Community building is not a specified category. | Hospital financial disclosures must be available to the public. The statute requires the State Department to provide an analysis of hospital fiscal reports available to the public upon request, as well as to the General Assembly. |

| | | | | |
|---|---|---|---|---|
| **Maryland** | Nonprofit hospitals must file an annual community benefit report, including costs of community benefit initiatives. Reporting elements are specified in the form and instructions provided by the Health Services Cost Review Commission. | Charity care and Medicaid assessments are line items on the provided form. Bad debt and other government program costs are not. | Community health improvement services and community building are included on reporting form, with categories mirroring Schedule H. | Reports filed become public record. The Health Services Cost Review Commission is responsible for compiling and summarizing community benefit information from individual hospitals into a publicly available statewide report. |
| **Minnesota** | Each hospital must file an annual report of expenses, including community benefit expenditures such as charity care, in addition to a balance sheet detailing the assets, liabilities, and net worth of the hospital. Detailed instructions are provided for report. This annual report is filed with the Commissioner of Health. | Cost of charity care, subsidized services, bad debt, and government programs are reported separately. | Community building is included in the statute. The instructions define categories mirroring Schedule H. | The Commissioner of Health is required to prepare a report on the community benefit numbers of all hospital data. This report aggregates total charity care and state programs. |
| **Mississippi** | Property tax exemption is based on hospitals using revenue for charitable purposes. Reporting requirements are not specified. | Reporting requirements not identified. | Reporting requirements not identified. | There is no requirement for aggregated public reporting. |
| **Nevada** | Hospitals must file annual reports and financial documents detailing community benefit expenses with the Department of Health and Human Services. The format is not standardized. Separate of this report, hospitals submit all bills for "indigent" care to the local board of county commissioners. These expenses are eligible for reimbursement after threshold of 0.6 percent of net revenue is met. | Only indigent care is reported for reimbursement. Bad debt is not included in the definition of community benefit or named elsewhere in the statute. Medicare costs are required in the annual hospital report, while Medicaid or other means-tested programs are not included. | Statute does not use the term "community building," but its definition of community benefit includes goods and services that could include Schedule H community building activities. | The law does not require aggregated reporting, but specifies that hospital reports must be available to the public upon request and posted online. |



https://uknowledge.uky.edu/frontiersinphssr/vol2/iss1/3
DOI: 10.13023/FPHSSR.0201.03

| | | | | |
|---|---|---|---|---|
| **New Hampshire** | Every "health care charitable trust" must submit an annual community benefit plan, including a report on the unreimbursed cost of activities from preceding year and projected for the next. A form is provided. Community benefit plans are submitted to the Director of Charitable Trusts in the Attorney General's office. | Charity care, subsidized health services and costs of government programs are reported separately. Bad debt is not included in reporting. | Community building activities are separate reporting areas on the form, with specific categories similar to Schedule H. | The individual trust and the Director are required to make reports available to the public. There is no requirement for aggregated public reporting. |
| **New Mexico** | Each non-federal health care facility must report detailed record of charges and discharges for their prior fiscal year. Reports are submitted to the New Mexico Health Policy Commission. | Charity care, bad debt, and Medicaid and Medicare charges and discharges are reported separately. | Community health improvement services and community building are not included in statute. | There is no requirement for aggregated public reporting. |
| **New York** | All hospitals are required to report financial transactions annually for reimbursement from the indigent care pool. Separately, nonprofit hospitals must file "implementation reports," documenting performance meeting community needs and providing charity care. Records and hospital plans are filed with the Commissioner of Health. | Bad debt and charity care are reported separately in transaction records. Charity care is also included in nonprofit hospital reports. Government-sponsored programs are not included in the statute. | Community building activities are not included in statute, but requirements include reporting on how hospital is meeting health needs of community and improving access for underserved. | Nonprofit hospital reports must be made public. There is no requirement for aggregated public reporting. |
| **North Carolina** | Hospitals submit annual, audited reports of activities to the City Mayor or the Chairman of the County Board of Commissioners. Reporting categories are not specified in statute. Retirement facilities report uncompensated care for property tax exemption. | Reporting categories are not specified. | Reporting categories are not specified. | There is no requirement for aggregated public reporting. |

| | | | | |
|---|---|---|---|---|
| **North Dakota** | Hospitals must provide charity for tax exemption. Reporting requirements are not specified. | Reporting requirements not identified. | Reporting requirements not identified. | There is no requirement for aggregated public reporting. |
| **Oregon** | Each health care facility is required to complete a Community Benefit Report annually. The provided form and statute break out detailed reporting categories. Facilities file Community Benefit Reports with the Office for Oregon Health Policy and Research. | Charity care, Medicaid and Medicare are reported separately. Bad debt expense is excluded from reporting, but is included on worksheet for calculating cost-to-charges ratio. | Community health improvement and community building are both listed as community benefit categories, with categories mirroring Schedule H. | The Office for Oregon Health Policy and Research must submit a report to the Governor and the Legislative Assembly every other year. The report must be available to the public. Information must be reported "by hospital"; aggregate reporting is not required. |
| **Pennsylvania** | Hospitals report uncompensated care to receive payments under the state's Uncompensated Care Program. Reporting requirements are determined each year by the Department of Public Welfare. The department determines hospital eligibility for program, assigns "uncompensated care scores," and calculates payments to qualified hospitals. | Charity care and bad debt are reported separately. Categories for costs of government programs are not included in the statute, but the Department may collect data from the Centers for Medicare and Medicaid Services to calculate hospital's uncompensated care scores. | Community health improvement services and community building are not included in statute. | The Department of Public Welfare prepares an annual report for several committees of the Senate and House of Representatives, which is also available to the public. The report must name qualified hospitals and uncompensated care scores. Aggregate data reporting is not required in the statute. |
| **Rhode Island** | Hospitals submit annual report of uncompensated care for licensure. The Director of the Department of Health determines if levels of uncompensated care provided by hospitals are adequate. | Charity care, bad debt, and contracted Medicaid shortfalls are reported separately. | Community health improvement services and community building are not included in statute. | There is no requirement for aggregated public reporting. |



https://uknowledge.uky.edu/frontiersinphssr/vol2/iss1/3
DOI: 10.13023/FPHSSR.0201.03

| | | | | |
|---|---|---|---|---|
| **Texas** | Nonprofit hospitals must submit an annual community benefits plan, and disclose amount and types of community benefits provided. Elements are detailed on standardized form. Hospitals must provide a minimum charity care amount, and report value of tax exemption. Plans and forms are submitted to the Center for Health Statistics in Department of State Health Services. | Charity care, subsidized health services, bad debt, Medicare, Medicaid, and other government programs for "indigent care" are reported separately on the required form. | Community health education costs are reported on financial data form. Other community building categories are not identified. | The Department of State Health Services is required to submit an annual report to Attorney General and comptroller with amount of charity care, government-sponsored indigent care, and other community benefits each hospital or system provided. Aggregate reporting is not specified. The report must be publicly available. |
| **Utah** | Hospitals must submit financial accounting to the Utah State Tax Commission for property tax exemption. Hospitals must provide "gift to the community" (charity care and other community benefits) which exceeds property tax liabilities. | Unreimbursed care (charity and subsidized care), and medical discounts (Medicare, Medicaid, and other government program) are counted in the total "gift to community." Bad debt is not a specified reporting category. | Hospitals submit financial data for "community education and service programs," as well as descriptions of "unquantifiable community gifts." | There is no requirement for aggregated public reporting. |
| **Virginia** | All health care institutions must submit a detailed, annual "historical" filing including revenues, expenses, assets and liabilities, and units of service, along with certified, audited financial statements. | Charity care and bad debt are not named in statute, but are required of the Board of Health report. | Community health improvement services and community building are not included in statute or Board of Health report. | The Board of Health is required to publish a report annually including operating profits, losses and deductions from revenue (including bad debt and charity care) from data provided by hospitals. The statute does not require report to be public. |
| **West Virginia** | Hospitals must maintain records of charity care requested and provided, and make aggregate data publicly available each year to qualify for property tax exemption. | Only charity care is required. Statute includes bad debt and Medicaid shortfalls as justifications for tax exemption, but does not require reporting. Medicare is not named in statute. | Statute's definition of charitable use of property includes "volunteer and community services" justifying hospitals' tax exemption. | Hospitals must make report publically available, and file data with the West Virginia Health Care Cost Review. There is no requirement for aggregated public reporting. |

| | | | | |
|---|---|---|---|---|
| **Wisconsin** | Hospitals are required to submit Uncompensated Health Care Plans (narratives of charity care policies, in which they specify their own definitions), as well as detailed financial data for previous and projected years. Plans and financial data are submitted to the Department of Health and Family Service. | Charity care and bad debt are reported separately for previous and projected upcoming fiscal years. Uncompensated costs of government programs are not included in financial reporting categories. However, deductions from gross revenue (such as contractual allowances) are required to be reported. | Community health improvement services and community building are not included in statute. | The Department of Health and Family Service must submit an "Uncompensated Health Care Services Report" to the governor and the chief clerk of each house of the legislature. The report must include the number of patients who received uncompensated care at each hospital and the total expenses of that care. The granularity of the report is not specified. |



https://uknowledge.uky.edu/frontiersinphssr/vol2/iss1/3
DOI: 10.13023/FPHSSR.0201.03